P R O C E E D I N G S

DEPARTMENT OF LABOR AND INDUSTRIES
PUBLIC HEARING
ERGONOMICS

Washington State Convention and Trade Center
800 Convention Place
Seattle, Washington

DATE: January 5, 2000

REPORTED BY: Wade Johnson, RPR

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A P P E A R A N C E S

DEPARTMENT OF LABOR AND INDUSTRIES STAFF IN ATTENDANCE:

MR. MICHAEL WOOD - Program Manager

MR. SELWYN S. WALTERS - Rules Coordinator

MR. TRACY L. SPENCER - Program Manager

MR. JOHN PEART - Industrial Hygienist

DR. MICHAEL SILVERSTEIN - Assistant Director for Workplace Safety and Health

MR. RICK GOGGINS - Ergonomist

MR. JOSHUA J. SWANSON - Administrative Regulations Coordinator

MS. JENNY HAYS - Safety and Health Specialist

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I N D E X

SEATTLE, WASHINGTON; WEDNESDAY, JANUARY 5, 2000

6:55 P.M.

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THE ASSEMBLY OF THE PUBLIC HEARING, regarding Ergonomics, convened, Mr. Selwyn Walters and Mr. Michael Wood, presiding,

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O P E N I N G C O M M E N T S

MR. WALTERS: Good evening, ladies and gentlemen. I now call this hearing to order.

This is a public hearing sponsored by the Department of Labor and Industries. My name is Selwyn Walters. I am the Agency Rules Coordinator. And with me, as co-hearing officer, is Michael Wood, the Senior Program Manager for WISHA Policy and Technical Services with the Department. We are representing the Director, Gary Moore.

For the record, this hearing is being held on January 5th in Seattle, Washington, beginning at 6:47 p.m. The hearing is authorized by the Washington Industrial

Safety and Health Act, as well as the Administrative Procedure Act.

Once the formal hearing is closed, staff will be available for additional questions. If you have not already done so, please fill out the sign-in sheet located at the back of the room. This sheet will be used to call forward individuals for testimony and to ensure participants are notified of the hearing results.

For those of you who have written comments that you would like to submit, please give them to Jeff Grimm, Jenny Hays, Josh Swanson, in the back of the room who are waiving to you.

We will accept comments until 5 p.m. on February 14th, 2000, for those unable to submit comments today. Comments may be mailed to the Department of Labor and Industries WISHA Services Division. The address is Post Office Box 44620, Olympia, Washington. The zip is 98504.

We are also accepting comments by e-mail, and the e-mail address is in your packets, but I will repeat it. It's ergo, e-r-g-o, rule, one word, at lni.wa.gov, or you may fax your comments to us at (360) 902-5529. Please remember that your fax comments should be ten pages or less.

The court reporter for today's hearing is Wade

Johnson of Starkovich Reporting, and you may purchase transcripts of today's proceeding from the reporting service. Also, copies of the transcripts will be available on the WISHA home page, and the address for that page, and you will be bear with me, is www.lni.wa.gov\wisha\ergo. These transcripts will be available online within about three weeks. Any request for copies of the written transcripts submitted to the Agency will be forwarded to the court reporter. And I'd like to remind you that the court reporter does charge for transcripts.

Notice of this evening's hearing was published as 99-23-067 of the Washington State Register on December 1 and December 15th, 1999. Hearing notices were also sent to interested parties. In accordance with section 49.17.040 of the Revised Code of Washington, notice was also published 30 days or more prior to this hearing in the following newspapers: The Journal of Commerce, The Spokesman Review, The Olympian, The Bellingham Herald, The Columbian, the Yakima Herald-Republic, and the Tacoma News Tribune.

The hearing is being held to receive oral and written testimony on the proposed rules. Any comments received today, as well as any written comments that we receive later, will be presented to the director.

In order to evaluate the potential economic

impact of the proposed rule on small business, the Department completed a Small Business Economic Impact Statement in accordance with the Regulatory Fairness Act. A copy of that statement should be part of the package you have at the back of the room.

We will allow ten minutes for testimony. If time permits, we will allow additional testimony be given after everyone has had an opportunity to speak. Please keep in mind that we have allowed a full month to receive written comments, the cutoff date being February 14th, 2000.

I would like to remind you that that is not an adversarial hearing. There will be no cross-examination of speakers; however, we may ask clarifying questions.

As stated above, when all speakers on the hearing roster have had the opportunity to present their testimony, we will provide the opportunity for everyone who so desires to present additional testimony.

In fairness to all parties, I ask your cooperation by not applauding or verbally expressing your reaction to testimony being presented.

If we observe these few rules, everyone will have the opportunity to present their testimony and help the Director to consider all viewpoints in making a full decision.

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O R A L T E S T I M O N Y

MR. WALTERS: In an effort to expedite the process, I will call panels of testifiers generally in panels of three. So, at this time, we will take oral testimony. Please identify yourself, spell your name, and identify who you represent, for the record.

The first panel is Sally -- forgive me for butchering your names -- Bearce, Kate Gartshore, and Joane Keehan. After that panel comes up, Christine Lakey, Sherry Davenport, and Nancy Wright should be prepared to testify.

MR. WOOD: I noticed some concerned expressions when someone said that we will allow ten minutes for testimony. That's up to ten minutes per person, although, you don't need to feel compelled to use it all.

MR. WALTERS: Sally Bearce, Kate Gartshore, and Joane Keenan. Ms. Bearce.

MS. BEARCE: Hi, I'm Sally Bearce. I represent the OPEIU Local 8. I have carpal tunnel syndrome, which is also known as an occupational disease. I am in favor of proposed legislation for ergonomic standards for the workplace and urge the Department to implement the ergonomic rule.

Since January 30th, 1998, I have struggled with the ongoing pain of carpal tunnel syndrome. Labeled as an

occupational disease, it was the direct result of the absence of an ergonomic setting provided for me at my work desk, according to my healthcare providers.

After a long period of pain, treatment, and surgery, I am now told by the doctors that my condition is fixed and stable. I agree with this, but must point out that I am, by no means, cured. My whole life, both professional and personal, has changed, and each day is a challenge to deal with the pain and the numbness and tingling sensations that I feel.

Many days I maintain a normal routine; however, the pain is never completely gone, and some mornings I awaken to such an amount of pain, with the inability to use my hands for even the simplest task, such as getting ready for work and driving to work. These are the days when I simply cannot come into work or need to work less than my eight hours and, thus, have been granted the FMLA, which is the Family Medical Leave Act, to use for time loss at work.

If my employer had initially provided ergonomic instruction and assistance to set up a desk for me, the following expenses could have been avoided: The expense of my treatment and surgery, which has been over $4,000; the expense of my ongoing time loss, which is inestimable; the monetary award, based on the impairment rating; and the ongoing responsibility for treatment, should my condition

worsen during my lifetime.

An ergonomic specialist was recently utilized when our office relocated. Since then there's been a low to no amount of complaints by my coworkers of carpal tunnel or of back pain, and there's also been a significant boost in employee morale because pain can be emotionally debilitating.

MR. WALTERS: Thank you.

Kate Gartshore.

MS. GARTSHORE: My name is Kate Gartshore, and I've been working at Harborview Medical Center as a registered nurse on the Rehabilitation Unit for over 12 years now. I'm a member of SEIU 1199 member.

I have been injured on the job at Harborview doing routine patient care in the first seven years of my career more times than I have working for the Washington State Ferries System, during the same amount of time, using heavy equipment to push and pull off of ferries, to load and unload passengers, and using heavy equipment on the dock to help unload the boats.

I've seen the acuity at Harborview of patients increase incredibly over the years, as well as patients' average weight, as well as the general public. And in the time that I've spent in rehab, I've seen patients' stay decrease, shorter time, shorter length of stay, which means

more intense rehabilitation, less time for the same amount of work to get people rehabilitated.

I think nurses in rehab are aware of good body mechanics. We work closely with physical therapists and occupational therapists to train our patients to use safe body mechanics for mobility. Nurses are trained by physical therapists to transfer patients in bed to wheelchair and commode chairs.

Nurses on rehab usually have an assignment load of three patients, one of which is a patient who has been paralyzed because of a spinal cord injury, a stroke, burn, or some other kind of debilitating disease. We have a time frame in which to prepare these patients to be ready for therapy. To get them ready for therapy means taking care of their hygiene, their bowel and bladder needs, dressed, teeth brushed, up in their chairs before therapy in the morning.

In spite of using good body mechanics at the bedside, nurses spend countless hours each day bent over at the waist caring for patients, kneeling or squatting, attending to patients' needs while patients are on the commode chair or in the wheelchairs, and transferring heavy paralyzed patients three to four times within an eight-hour workday. This puts nurses at risk for musculoskeletal injuries.

I, myself, know of four nurses who are on the rehabilitation unit where I work who have left nursing on a permanent disability because of injuries to their backs and to their spinal column while at work. Personally, I've been knocked to the floor when a patient landed on top of me during a transfer while in a bathroom because of the patient's uncontrollable leg spasms that ejected them from the wheelchair.

I've worked with stroke patients who are unaware and unable to control one side of their body. And what they do is they pull against you. It takes all your strength to get them to come to a sitting position after they are laying in bed. I have worked with patients who are so disabled and deconditioned that they need three to four people to help them with turning in bed every two hours or positioning upright so that they can have their basic needs met, such as eating and taking medications.

I've had three injuries myself, to my back, neck, arm, because of repetitious movements, heavy lifting, bending for hours over the bedside doing patient care. I injured my back, resulting in a tingling sensation and numbness in my fingers and my right arm to my neck and back after a heavy woman, a 200-pound woman, her legs gave out during transfer. I was able to take time off and return to work after a few days, four days. I was much younger

then. I don't think I could do that now.

Less than a month later, I injured my right arm and wrist. I have right lateral epicondylitis, which is a tendon tear, and wore a splint on my right arm for a month while working. I was protecting my back and using my arm muscles doing routine nursing care. Two weeks later I injured my right knee, a right medial meniscus tear. I took medication, attended physical therapy for nine weeks to help that, as opposed to surgery. Even today I must guard myself and my knee against stress during transfers and lifting patients up in bed.

My last injury was in 1997. I was experiencing lower back pain at work that continued for two months that I attribute to heavy lifting of patients, repetitive movements, continually bending from the waist in awkward positions while doing my job, patient care. After a bone scan, the pain was diagnosed as a facet arthropathy in my lower spine, which means unusual wear and tear on the facet in your spinal cord.

I've always been a fairly healthy person and an active person off the job. I've been able to work in my field that I enjoy, nursing, but I believe my past injuries and my continued stress on my body at work will limit my ability to work in this field in the future.

During the time I was injured, it would have been

more ergonomic using mechanical devices to transfer patients to lift patients, or it would have been better to use a lift team, as opposed to one person doing this.

I believe increased ergonomic laws will prevent further injury to others, myself, and colleagues. Thank you for letting me testify at this public hearing.

MR. WALTERS: Thank you.

Ms. Joane Keenan.

MS. KEENAN: Hello. Thank you.

My name is Joanne Keenan. I also am an RN at Harborview Medical Center, and I am represented by District 1199 and SEIU, as well.

For over 15 years my work has been as a permanent hospital staff nurse at Harborview Medical Center in Seattle. During this time, I have seen many of my fellow employees have been injured on the job, back, shoulder, arm, neck, and wrist injuries, as a result of either repetitive patient care activities or as a result of specific patient care incidents.

I have had two lower back injuries as a result of patient transfers and one neck injury resulting from attempting to restrain an out of control psychiatric patient. Even when there's not been a specific event, after a busy shift or several days on the floor, I often experience lower back, shoulder, or neck pain or arm

numbness. I often hear my coworkers complain of similar physical discomforts. These problems worsen as time goes on.

Direct patient care demands repetitive bending over, over patients' beds or wheelchairs, for such activities as physical assessments. That's listening to breath sounds, bowel tones, taking vital signs. We also draw blood, start IVs, give medications, feed patients, bathe patients, change linen, doing wound care, EKGs. If we're not hunched over patients, we're usually hunched over computers.

RN work includes much heavy lifting, patients and equipment. As length of patient stay becomes shorter, more and more tests and procedures need to take place in a typical shift. An increased patient acuity results in more and more dependency upon staff to provide heavy care, including an increased number of transfers to and from stretchers or wheelchairs in a typical shift.

Also, reduced staffing -- reduced staffing, we see it a lot -- means that there are fewer people available to assist with transfers. On our floor if we have a hospital assistant, there will only be one for 32 beds. Nurses try to help each other, but often we're so busy, because all of us are involved in our own situations. And way too often we simply move, reposition, or even transfer

patients without help or with not enough help.

When nurses hurt or become injured, there's a disincentive to report these things. Many of us fear we will have trouble transferring or finding other positions if we have a record of on-the-job injuries, especially back injuries. Many of us have suffered discomfort, sought outside treatment, and simply worked as best we could despite injuries.

When considering monitoring and enforcing hospital ergonomic safety, I ask you to consider the following three things: First, all nurses are at high risk for ergonomic injury. Two, adequate staffing is essential to prevent injuries. And, third, though education of staff is important, enforcement of safety rules is crucial.

Institutions need to be held to adequate staffing and providing proper equipment. Hospitals must not be trusted to identify their own risks. Inspections must be frequent and unannounced, and whistle blowers must be protected.

Thank you for an opportunity to voice my opinions on this important issue.

MR. WALTERS: Thank you.

I'll call Christine Lakey, Sherry Davenport, and Nancy Wright. And after this panel Jay Herzmark, Matthew Keifer, and Patrick Burns should be prepared to testify.

Ms. Lakey.

MS. LAKEY: My name is Christine Lakey. I work at the University of Washington Medical Center. I work in a molecular diagnostic laboratory. And my coworkers and I use the latest technologies for clinical diagnosis of genetic and molecular disorders.

Just over two years ago, we brought two small laboratories together, and upon talking to each other, found that we were all suffering from the same pain from repetitive work that we do. And upon asking for help, we found that there was nothing available in the state for laboratory ergonomics.

So, working with our laboratory director, the six of us in our laboratory became proactive, so that we could get better. We formed a support group with colleagues in another laboratory, who have the same disorders going on, and thorough our collective experience and knowledge and detective work, began to employ a variety of remedies to help us get better. And these include lowering some of the bench tops to accommodate the variety of heights.

We have people from five-eleven to four-ten, all working with the same equipment and in the same work area. Lowering the waste containers to bench top height, trying new ergonomic sit/stand chairs, and most importantly replacing all of our pipettes with ergonomic pipettes. And

so far as I know, there is one company now that is catering to the ergonomic problems in laboratories, and they're doing quite a business in Seattle.

We're also very diligent about limiting the number of pipetting events per week and being very good at stretching every 20 minutes. Some of these experiments can go on for several hours, and it's become very important to stretch and know when your body has had enough.

When we started looking for help last year, there was no help available in the state for laboratory related repetitive strain. Only after diligent search of the literature did we find published guidelines for laboratory ergonomics from NIOSH and found several web sites from other universities that were encountering the same problems. We found that virtually everyone who does PCR, Preliminary Chain Reaction, work gets repetitive strain.

Currently, our department has formed a task force to explore laboratory ergonomics with emphasis on education and awareness. We found an ally in our risk management department. Since the State Employee Health and Safety has no experts in laboratory ergonomics, we've been trying to get two experts from Immunex to give us their 45-minute, $75 workshop. It's quite a task getting this done. We've been trying for nine months.

We've created a website for laboratory

ergonomics. And all of this has come because we, the employees, found the solutions. We're working with our coworkers and scientific instruments. We're working with a machine shop. They made us foot stools, they made us laboratory aids, things that help us in opening repetitive tubes and such.

Unfortunately, I still see many of my colleagues suffering and continuing to come down with repetitive strain because the information that we have gathered comes from the bottom. It hasn't come from the management yet. It's not fully available to all, and it's not being used in an education manner for new people, new hires, and people that continue to learn new technologies.

I would like to caution the State of Washington as the human gene projects nears completion, more of these tests will become clinical tests and become common in all laboratories and more and more technologists will be at risk for this very preventable disorder.

Thank you for letting me testify.

MR. WALTERS: Thank you.

MR. WOOD: I have just a quick question. You mentioned creating a website.

MS. LAKEY: Yes.

MR. WOOD: Do you happen to know what the website address is for that, offhand?

MS. LAKEY: I do not, but it's on the University of Washington Medical Laboratory site.

MR. WOOD: Okay.

MS. LAKEY: And I can get that to you. I don't have the information right now.

MR. WOOD: Thank you.

MR. WALTERS: Thank you.

Ms. Davenport.

MS. DAVENPORT: Yes. My name is Sherry Davenport. I belong to the OPEIU. I work at a small nonprofit law firm. I'm the legal clerk there. There are three regular staff employees, and we have quite a few volunteers. But I started there a little over a year ago, about a year and three months ago, and shortly, not long after, I started having problems with my shoulder and my back, which, because I really needed the job, I didn't say too much about. And the times that I did say anything, it was sort of like, well, this is the job, this is, you know, what you have to do. And the volume of work is so great that, you know, it was all -- I just tried to get through every day.

Some of the things that I noticed right away were causing problems were stapling, punching holes, filing, the transferring of files around. And those were things that I did tell my boss right away that I was having problems

with, but there was just nobody else to do it. And we tried to find some volunteers to help, and there have been times when people have come in to help.

I did not open a claim with L&I until this last July because I had other health problems that seemed to be more important, and I just didn't realize that it was something that could be -- that would qualify, because it was sort of a repetitive type thing, and it was part of -- not any particular incident would cause the problem. It was just an ongoing kind of thing.

But I did miss work because it just got so bad that I couldn't go into work. And I told the doctor about it, and so I had an L&I claim opened. I missed work numerous times. I have pain going down my arm, numbness in my hand. And I'm going to physical therapy, seeing an acupuncturist. I've seen an occupational medicine doctor at Group Health who has requested a workplace evaluation on a couple of different occasions. Nothing has happened.

And my employer is willing to do what they -- they're willing to do what they can, but it's, you know, we're short on funds, and they can't just spend all kinds of money buying all sorts of equipment, and they don't even know if it will help.

So, what I'm looking at now is maybe starting to go to reduced hours, which would be a real problem for my

employer or taking off some time from work. I've used my sick leave and my vacation days to take time off and go to doctor appointments, and I don't really think that that's fair, but I know that I'm really needed at work.

In the long run the doctor told me I might have to think about leaving that job. And what would I do? You know, because it's just getting worse as time goes on. So, you know, hopefully, if there were a rule implemented, it would help L&I to help deal with situations like this, and maybe, you know, I never would have had this problem to start with. And that's about all I have to say. Thank you.

MR. WALTERS: Thank you.

Ms. Wright.

MS. WRIGHT: Hello, my name is Nancy Wright, and I'm a molecular biology technician at the University of Washington Neurology Lab and Medical Center. And six years of extracting RNA, DNA, and then doing assays, the PCR assays, involving repetitive manipulations of tiny tubes, pipettes -- we use those to measure -- and a vibrating platform called a vortex we use for mixing everything, has left me with painful arthritis and tendonitis in both my hands and my arms.

And I've had to switch to a different position in my laboratory and make many changes in my personal life to

accommodate the reality of weakened limbs. And I don't think my problems resulted from gardening and sewing and home computer work, because I'm not -- you know, wasn't into those kinds of things when I started having these problems, rather, they resulted from performing the same joint-jarring motions hundreds and thousands of times a week.

Basically, for the new biology, you open a tube, you pipette it, you close it, and you vortex it. You put it in a centrifuge, and you take it out, and then you start over again, and you send your specimen through a series of those types of motions. And wearing single and double gloves and working with extended arms in a bio safety hood, which is required by OSHA and WISHA, it aggravated the damage.

And I don't really think my injuries are a function of age, although I think healing is more problematic for a middle-aged person. Coworkers in their 20s and 30s also experience similar symptoms, to a greater or lesser extent than I have.

And I certainly don't have any complaint about my employer, that I feel the lab responded to problems with investment in expensive ergonomic equipment, not for me, but for everybody, greater task flexibility, and job reassignment. However, had a workplace ergonomic plan

existed several years ago, today I probably would live without a wardrobe of various braces and supports for my thumbs and wrists and elbows.

And I feel very strongly that the current L&I process that focuses on individuals is insufficient. It seems like a great amount of money is poured into documenting and treating an injured employee when the money might be better used to prevent injuries to other workers. I mean, maybe it's too late to help that worker do that job.

And I really think a mindful evaluation of potential ergonomic risk is particularly important in the new technology workplaces where the injury statistics are still in the making.

And I like the caution zone concept. I think it's as good a place to start as any. And if the major expense of a workplace is payroll, it makes sense to prevent workers from injury.

A customized ergonomic plan could help many ways: Identify risk areas, determine the most appropriate purchases of equipment and furniture, to guide decisions about new protocols, to educate new workers, and to outline corrective measures to help workers in that workplace with repetitive stress problems.

And I think an ergonomic plan would also make

employees responsible for their own well-being, i.e., they need to uses ergonomic equipment, even though it often is less convenient or doesn't work as well or takes longer or whatever. And I think really employees should be responsible for monitoring their own well-being and reporting symptoms early enough to benefit from treatment or to benefit from a modified work assignment.

A state mandated ergonomic program would encourage manufacturers to invest time and research to design better equipment and assay kits. There's a lot of so-called ergonomic stuff out there. There's just junk. I think in my own field the currently ergonomic pipettes and tubes and racks, they have a great deal to be desired. I'm eagerly awaiting the second generation of ergonomic lab equipment with improvements.

And as a humble Tech 1, I haven't had much success calling a vile manufacturer to suggest they produce some kind of overpriced plastic wrench to open their screw top tubes. It's just not cost-effective for them to bother, but if suddenly all the biotechs get on board with this ergonomic standards, then maybe they'll start listening.

I also think there needs to be more research, gender research. For instance, in my own lab, that many of the women report the same kind of problems that I have, but

only one of the men. So, someone needs to be looking into that when they're doing the studies about hands and what kind of equipment is effective.

And, finally, I think that ergonomic education for both employees and supervisors is crucial for success. An in-house ergonomic plan would make safety training more relevant to workers, particularly, if the format is hands-on, rather than lecture. I mean, typically, you go, you snack, you snooze, you sign a paper, and then you go. You've heard a lecture, but, yeah, let us try out the equipment and discuss, as fellow employees, what works and what doesn't work and how can we make it better. And I think this program would encourage this type of an interactive safety program.

And I think the supervisors need to realize they have a responsibility to assign work in a way that minimizes repetitive injuries, even if there's a lower output, but I think the employees have a responsibility to make their needs known. I mean, the supervisors can't be psychic.

And I hope the state proposal will be accepted and that employees will be given a role in developing ergonomic plans in their workplaces. In my workplace most of the changes were the result of employee suggestions. And I hope that employers will accept the plan in the

spirit of protecting their most valuable resource, their employees, rather than seeing the proposal as yet another tiresome case of state-mandated paperwork. Thank you.

MR. WALTERS: Thank you all for coming.

Jay Herzmark, Matthew Keifer, and Patrick Burns. And after this panel, Frances Alexander and David Kalman should come forward.

Mr. Herzmark.

MR. HERZMARK: My name is Jay Herzmark. I'm here representing the Washington Federation of State Employees. So, it's part of the American Federation of State, County, and Municipal Employees. We represent state workers across the State of Washington and also across the country.

I just wanted to mention, I'm an industrial hygienist, and I work for my employer's safety department. My employer does have an ergonomic program. In the past, I did hundreds of ergonomic evaluations as a member of the safety department. I did them in mail sorting operations, in warehouses, in laboratories, offices, clinics, and probably my favorite was the money counting operation.

And sometimes the departments would make changes, oftentimes not, though. A lot of these changes that I recommended, sometimes they could be as simple as putting a desk up on 2-by-4s because the desk was too low for

somebody that was tall. Very rarely did they cost anything more than a new chair.

Now, though, nobody in our Department does ergonomic evaluations. Our employer has cut back on those, and the reason that they've given for that is, and I just want to emphasize exactly what they said. They said they don't do them because they're not required. In fact, just an hour before this meeting, I had to attend a hearing because my employer is proposing to suspend me for five days for doing an ergonomic evaluation on my lunchtime.

Meanwhile, you know, we're not doing ergonomic evaluations, we're not making recommendations for changes in the workplace, but many, many employees are getting hurt. Ergonomic injuries are the most expensive part of our workers' comp program.

I did say we had a program, an ergonomic program, and our ergonomic program consists of, we make some classes available where we teach people how to arrange their own workstations, and we also have some written guidelines that are available.

I found that the UW program is about as effective as a blank piece of paper, in many cases, but that's not to say that it's completely ineffective, because I found that if you cut a hole in a blank piece of paper and you stick your thumb through it, you can kind of tape it up and use

it as a wrist splint, like this one here. It's a little difficult to put on yourself.

MR. KEIFER: Do you want some help with that? I'm a doctor.

MR. HERZMARK: Thank you. So, now we have our -- this is as effective as our employer's ergonomic program. We at AFSCME and Washington Federation of State Employees do appreciate that L&I has gone to the extreme effort of proposing this standard. We really do appreciate it, and we think it would be very helpful. And we just want to say that we think it's pretty obvious that most employers -- I shouldn't say most of them -- that many employers will not do what needs to be done to make their workplaces safe unless they're required to. Thank you.

MR. WALTERS: Thank you.

Mr. Keifer.

MR. KEIFER: My name is Matthew Keifer. I'm an occupational medicine physician, and I'm here representing myself, but my affiliation should be stated. I work at the University of Washington in the Department of Medicine, Environmental Medicine. I'm the program director of the program Occupational and Environmental Health at the University of Washington.

I came here, basically, to reinforce what I thought was a very excellent first step towards reducing

the problems that face us in the work force. The ergonomic problems that really burden both the clinical management of occupational care, occupational medical care, and really burden the workplace in the United States.

I don't think it's important to go through the statistics because they've been said many times, but we are aware that three-quarters of a million ergonomic injuries happen on a yearly basis in the United States, and we really need to address that problem. It's an enormous burden economically for employers; it's an enormous burden for the medical system; and it's a tremendous burden for the employees.

In my own personal experience I've seen many patients, probably 10 to 20 percent of my patients are severely impaired by their ergonomic problems. Probably 25 percent in total is the number of ergonomic patients I see on a regular basis. So, I've had the experience of working through these cases, and they're not simple, they're not quick, and it usually takes a person as long to get better as it took them to get sick. As a result, they are injured for a long time, it's costly for the employee, and it's costly for the employer.

The stories that I heard earlier today of the people who came up here and testified about their own experience, I could go through and give you other examples

of people who have had similar experiences, who have been my patients. And it's really a tragedy. One of the greatest and most problematic parts of this is the fact that the tragedy is oftentimes not recognized by the employer. The employee does become a weakened worker, as a result of the liability to the workplace.

The employee, themselves, see themselves as a liability to the workplace, and it has an impact, not just on their physical well-being, but their mental well-being. So, the damage goes well beyond the physical damage that's caused by the ergonomic injury; it impacts the person's ego, strength, ultimately impacts their self-image, and often brings on conditions such as depression and other kinds of consequences. So, this is a problem that's very extensive, very broad, enormous in terms of its impact, and something that definitely needs to be addressed.

The one thing that I particularly am pleased about, in terms of the standard coming forth is the fact is that it's proactive. It doesn't wait for injuries. It asks that an assessment be done ahead of time. It asks the employers to look at their own workplace to come up with some of their own solutions. It's creative. It appears to me to be flexible and well thought out.

I want to point out an example of how effective some of these programs can be, because I think there's a

feeling that this is -- on the part -- that there's a feeling on the part of some people that this is a bit of hot air, that this is just rule making for the sake of rule making.

Recently there was an article published in the Journal of Occupational and Environmental Medicine, and it's a report from Johns Hopkins University of a program in which they had an integrated tripartite program of ergonomic assessment, medical assessment, and workplace evaluation with recommendations for improvement.

And over a period of 1992 to 1998, they effectively in Johns Hopkins University reduced the number of ergonomic medical assessments to near zero. At times it was actually zero for a year and then bounced up to nine or ten, at times, but they dramatically reduced their experience. Where they were normally having somewhere in the neighborhood of 100 per year, they effectively almost reduced to zero.

Initially, they did have slight increases, there was a slight bump as they brought this system on line, probably shaking out from the woods some of these cases that, basically, didn't have the courage to come forth earlier. But in the end they ultimately reduced their problem enormously and made an enormous impact economically and in the health of the workers.

So, for those who would say there's not much evidence for this, I would say there, in fact, is a lot of evidence for it. In fact, it continues to pour in. And as a medical professional, who sees these people on a regular basis, I applaud the work of the Department of Labor and Industries in moving forward on this rule making. Thank you.

MR. WALTERS: Thank you.

MR. WOOD: Dr. Keifer, can I get slightly more detailed citation for the record?

MR. KEIFER: It's December 1999 Journal of Occupational and Environmental Medicine, Volume 41, No. 12, and the author is Bernacki, B-e-r-n-a-c-k-i, Edward, page 1032.

MR. WOOD: Thank you.

MR. KEIFER: You bet.

MR. WALTERS: Thank you.

Mr. Burns.

MR. BURNS: Good evening. My name is Patrick Burns. I'm a carpenter. I've been a union carpenter for 26 years. I am a member of Carpenters Local 131 here in Seattle. I represent myself, but I think I carry the sentiment of many carpenters in the field.

Personally, I feel particularly lucky, in that being a carpenter for 26 years, I've seen a lot of

different work experiences that really cause a great deal of strain and suffering. I've had times in my life where I wondered if I would be able to work my trade again. And being in that position, I had to look at -- I look out and wonder if I'm going to be able to support myself, and, at the time, my daughter who was living with me.

So, the two particular experiences I've had as a carpenter, the first one happened when I was an apprentice in the first six months of my career. I was working for a company that builds concrete decks, concrete floors, the ones we all walk on. The process of building those floors is to use metal pans to build a beam in the floor for structural integrity.

Those pans, which are capped, weighed at the time -- this has changed since then -- but they weighed, at the time, 80 pounds. I'm six-foot-three. I was given a space of five-foot-six to strip these pans out, to pick them out of the ceiling, turn, twist, and drop them.

I was not -- did not have the correct physical stature to do the job. There is many men who can do that job, and do it day in and day out and go home okay. I had a back injury, that was a back injury at the age of 23.

Ten years ago, I was working on a framing job. We were remodeling a school in north of Seattle. I was working on a radial saw. I was working on a table that was

maybe this tall, and I had to bend over continually day in day out for two or three weeks. After a period of time, I began to experience a sharp pain in my back. If felt like a dull butter knife digging into my back continually. I had to stop my work process, go over to a place I could just hang myself by my hands to try to relieve the pain.

Finally -- and I didn't want to say anything. I didn't feel comfortable saying anything to my employer. This kind of sentiment that's being expressed now by L&I, being expressed by unions, and also being expressed by employers, just was not present at that time. I worried about my job.

But finally the pain got so bad I went to my employer and said, "I have to go to the doctor; I'm hurt." They allowed me to go to the doctor. I actually went to a chiropractor. I was surprised he was able to relieve the suffering in four visits. But, as soon as I was okay to go back to work, I was laid off. That's the dark side of these kind of situations, being that employers, once they realize they have a risky employee, get rid of them. We just don't fit in.

So, in total, about the sentiment of this and the intent of these new rules, I, personally, wholeheartedly endorse them. I know many of my brothers and sisters in the field endorse them. I hope the employers can

understand how strongly we feel about it and how important it is to us, because we want to work hard, we want to produce, we want to make them rich, we want enough money to be able to afford our needs in this economic environment.

Thank you very much.

MR. WALTERS: Thank you. Michael has a question.

MR. WOOD: When you described your initial injury, you referenced the fact that the weight of the beam has changed. I was just curious, has it increased or decreased?

MR. BURNS: Actually, it's decreased. What's going on is that there are engineers I believe working to figure out how to make these processes more safe and make it easier on employees. And the same company for whom I worked, used to have the worst safety record, I believe now is one of the best companies in the nation.

MR. WOOD: Thank you.

MR. WALTERS: Thank you.

Frances Alexander and David Kalman.

MS. ALEXANDER: I'm Frances Alexander. That's F-r-a-n-c-e-s. And I am a paralegal advocate. I'm a member of OPEIU locally. I work for a private nonprofit law firm. The work I do is kind of unusual because when one thinks of what I do they think, well, what repetitive

tasks do you do? The only thing is I write, about 90 percent of my job is writing by hand. The rest of the job is doing filing. And more and more times it's on the phone, I do hearings on the telephone. I represent claimants in unemployment hearings, so I do a lot of telephone hearings these days. But I write. I also do computer work, very little of that.

In the process of doing these tasks, I have developed a recurring tendonitis in my elbow and a trigger finger, my thumb in my right hand.

And ergonomic assessment would have prevented these injuries from occurring. I now cannot lift anything very heavy with my left arm because the tendonitis comes back. I have a tube, Styrofoam tube, that I put around a pen so that I can write without having pain. And I went to physical therapy and occupational therapy. I don't pick up files anymore because I can't grasp. When I first developed tendonitis, I couldn't hold a glass in my hand. I dropped it, and I said, "Well, something is wrong here." Obviously something was.

So, I can't file anymore. I can't go through files. I can't transfer files. I can't put the file in the file cabinet, take them out. I can't cross over my body anymore and things like that.

I believe that anybody who works with a computer

these days needs an ergonomic assessment as to the distance from the person that the computer is, the height, the keyboard, the chair, the distance that your legs are from the floor, where you put paper, if it's down flat that you're working from or up on a holder or whatever. Ergonomic assessments would reduce all of the injuries or most of the injuries that occur.

Also, when I do use the computer, which is very little for word processing, I notice that I feel a strain or a pulling in my wrists, both my wrists, which makes me have concerns that if I really had to use the computer on a constant basis, that I would develop carpal tunnel syndrome. And I'd rather have all this prevented than having cortisone shots in my joints in very tender places and possible surgery in the end.

So, I support the new rules that you're proposing. I think they should go further and mandate that ergonomic assessments be made in the workplace for all -- especially office work, but hospital work and all -- all work.

The other thing I would like to do is just take a moment, and this has nothing to do with ergonomic assessment, but since it's part of labor and industry here, I would like you to reevaluate your position on failing to recognize stress related -- work-related stress as a

workers' compensation injury. I'm talking about situational stress disorder and posttraumatic stress disorder and work-related stress.

There are too many walking wounded that are taking Prozac, Wellbutrin, Zoloft, and other antidepressants, that never needed them before, but have developed this in their job. And the Department of Labor and Industry doesn't recognize it as a work-related injury, and they should. Thank you.

MR. WALTERS: Thank you.

Mr. Kalman.

MR. KALMAN: My name is David Kalman, K-a-l-m-a-n. I am a professor of environmental health at the University of Washington and chairman of the Department of Environmental Health, and I'm here representing myself.

I would like to address my comments to two basic questions tonight. One is the scientific legitimacy of proposing a rule in ergonomics, specifically, whether or not the body of information available to this point is sufficient to allow one to make judgments about both the prediction of disease and the potential for reducing the incidents of disease. And then I'd also like to comment on the proposed rule, itself, at least in terms of its conceptual framework.

As a physical scientist and a person who has a

professional interest in health and safety, I wanted to come down and comment tonight because I am aware of a number of criticisms that have been offered of the undertaking to formulate and implement a rule governing ergonomic issues in the workplace and aimed at controlling musculoskeletal injuries and diseases.

I have been listening tonight and haven't heard a lot of commentary about those concerns, but I know from previous experience that it is a concern of some that the current scientific understanding of what causes musculoskeletal injury is insufficient to provide a certainty in distinguishing what workers are at risk from what workers are not or provide a level of certainty about what interventions will be effective and exactly how effective they will be.

And I'm here to offer the professional judgment that, while complete certainty is certainly lacking, and while there is clearly room for improved understanding, both of the mechanisms by which the injuries occur, and by an improved understanding of how to best manage these hazards, nevertheless, there is clear and convincing evidence that musculoskeletal injuries are widespread and represent a very significant burden, in terms of both workers and employers, and that significant reductions in this unfortunate experience can be achieved with

application of principles that are currently understood, and that as those understandings are improved in the future, there's every reason to expect that the efficacy of their ventures will get even better.

Certainty is a much desired thing, and, at the same time, we never have a level of certainty we would like to have when we move from a laboratory or a theoretical realm into the real word and try to solve real problems. But some of the things that we can be much less uncertain about than other things are that, number one, in the absence of any change, musculoskeletal injuries will continue to afflict a significant number, in the tens of thousands of workers ever year.

We can be certain that whatever emerging techniques are devised for managing these problems, that they will include analysis of workplace tasks, determination of what workers are engaged in activities that put them in awkward postures or at risk from heavy lifting and repetitive motions and vibration, and that the kind of analyses that are required under the current rule will be of use even as our ability to apply this information gets better and better.

So, in summary, I would say that I think there is an ample basis for being confident that the current rule is not only justified, but, in fact, is an obligation in

trying to manage this severe problem.

And in terms of the approach that's being offered, I find that it's a very reasonable one, in that it tries to strike a balance between the significant variation from workplace to workplace, permitting employers and workers to tune their particular approach to problems to the workplace and to the specific circumstances of each job and each industry, while at the same time creating a framework which will move the entire process forward.

Given the, again, the relatively less uncertain outcome, that without a rule, that some employers will not be responsive to this as a hazard affecting their workers, I think that the current approach of a developmental process leading to continued improvement in this area is appropriate, and I support it.

In some of the written materials that have been distributed from the Department of Labor and Industries comment has been invited on the specific question of whether six years is too fast or too slow. I would -- I guess my comment on that point is that I think that it would be a very good thing if there were incentives for workers -- for employers who are in a position to implement practices on a sooner time table than six years if those incentives could be devised and put forward.

Nevertheless, I think that it is respectful of

the significant challenge to workers, to employers, and to the state, as a group, to come up with the best and most effective techniques for managing these hazards to allow this developmental period for collaborative problem solving in terms of workplace. So, I believe that the six-year term is a reasonable one. Thank you for allowing me to make these comments.

MR. WALTERS: Thank you very much, both of you.

Is there anyone else who would like to testify? Would you come forward, please? Please state your name and tell us what you think.

MS. TAYLOR: My name is Kathi Taylor, and I'm here for OPEIU Local 8. I was listening to my fellow workers who have sustained their injuries in working in hospitals and nursing homes. And as my arm was tingling, I thought, oh, my gosh, I'm not the only one. I succumbed to a repetitive strain injury in California in 1985. I suffer all the same symptoms, all the same pain, and it's been going on for years and years and years, and it continues to get worse.

They addressed staffing levels. And the reason I asked the question earlier about economic considerations and what would an employer be held to as far as economic repairs or, you know, implementing things to reduce

repetitive strain injury, how far would they be required to go in order to do that, and I kind of got a vague answer.

In nursing homes understaffing, it is a large problem. It's a terrible problem, and I notice that in this state, as in California, at the time, there is no client-to-patient minimum staffing ratio, like one aide or one nurse to eight patients. Sometimes it will be one aide or one nurse to 13 patients, 15 patients, because someone's called in sick or because whatever or because they won't hire more staff.

That doesn't mean that the other requirements by the state to provide care for those clients decreases. They still have to be bathed and fed and changed and turned and all of those things within the same eight-hour shift, but instead you have three people doing all of those things instead of six or eight, which increases their repetitive strain or acute -- even acute trauma risk because they have to be faster and do more and stress themselves out as the day goes on.

But, I can hear a nursing home saying, oh, but we can't hire more staff. It would be economically impossible because it would decrease our profit margin. Okay, but I would say that there should be a staffing ratio implemented in this state to maintain the safety of, not only the workers, but of the patient or the client or the resident.

Because if they fall on top of you or if you slip and fall on top of them or whatever happens, the injuries could happen to everyone and then the employer has to pay out big bucks. When I injured -- I work nights. We had two aides for a whole entire facility full of people. And they train us how to turn and transfer. And if you do everything right, if you're doing 20 people an hour and you're going and lifting and turning them and you're doing that all night long, six times a night, five nights a week, and there are two of you for like 60 patients, that takes it's toll.

And when it finally put me out of commission, it cost my employer a lot of money to get me back to where I could go to work. It cost him thousands of dollars to retrain me, thousands of dollars for physical therapy, thousands and thousands and thousands of dollars for something that could have been prevented by an amortized cost of an aide over a time period that would have been much less impactful to his profit margin or to his L&I premiums.

My mother always said an ounce of prevention is worth of pound of cure. It's something we need to do. We need to prevent instead of cure, because if you don't pay now, you're going to pay later. Thank you.

MR. WALTERS: Thank you.

Could you state your name, please?

MR. MAVILLE: My name is Ken Maville, M-a-v-i-l-l-e. And I was asked by District 11 steelworkers to come down and talk to you. First of all, I'd like to thank you guys for being on the frontline in implementing this sort of thing.

I had an injury in June of 1998. I was twisting some valves, and I blew a disc out in my neck. I've since had it operated on, and I have a permanent problem. And I just want to say that this isn't going to help me much, but it's going to help our kids. They're going to have to go to work someplace. I hope it isn't under the same circumstances.

Don't expect all businesses to volunteer. This has to be something that's mandatory. Certainly a lot of them are interested in helping, and the company I worked for was, but they were a little late and a little short to change the valves over, just as they were in the process of doing it before I got injured. It was a question of we need production, and it's a question of we're budgeting for next month for the valves. And my understanding is, out of 20 valves, they've still got a couple that need to be replaced since then, but it's being done.

The people that I've worked with, most of them had tennis elbow from twisting these valves because it was

sticking. And one of the mechanics came up with a plan to fire them with air, make a switch that you just had to turn, and the valve would fire by itself. Very safe setup, very good for everybody's arm. This is what's being done now, so, actually, that problem is in the process of being solved.

But I would expect that all managers of all companies would see this as a necessity until something like what happened to me. They probably spent 50, $60,000 on me now, when you're looking at $800 a valve. You should have a system set up, of course, to inspect all complaints and to assess some kind of punishment for violations.

Insurance companies should be in the forefront of establishing some sort of education as to find out what the caution zones are and how to take care of them. And I think probably when you want to implement a better way or suspect that there is a better way to do the job, I think going to the people that do the job and ask them what their opinions are, they may have a better idea. It may be a cheaper one at that. It's sufficient to say, I really appreciate this forum, and I appreciate you being -- California is the only other state -- I appreciate you being at the forefront of this. Thank you.

MR. WALTERS: Thank you.

Would you state your full name, please?

MR. WERT: Yes, my name is Joe Wert, W-e-r-t, and I'm a union representative with UFCW Local 1001, and I represent healthcare workers including nursing home workers.

The first thing I'd like to say is that I concur with my sister at the end of the table, that at least in nursing homes, a huge percentage of these types of injuries could be alleviated if there was some mandatory staff-to-patient ratio. I just negotiated a contract in Enumclaw, and that was one of the biggest issues in negotiations was patient/staff ratio.

I know that California has this in their ergonomics rules. My understanding is that only applies to hospital, it doesn't apply to nursing homes. That's an error in their part. I wish Washington could put something into their rules regarding this.

I would also like to say that we're very happy with the work you've done. I realize the stumbling blocks you came across with employers, and I'd like to address that. There's an old staying in labor that we never have happy employees calling us up because they want to join the union. And I think the same thing can be held true with legislation, that if the problems didn't exist, you guys wouldn't have been trying to work up with this bill. To say that the problems don't exist or that we don't need

these type of rules is sticking your head in the sand.

The third thing I'd like to address is this. I have a vested interest in this. My wife's a vocational rehabilitation counselor. And if these rules are implemented, it will probably cut into her business, but I spoke with her, and she said that's business she'd gladly lose. Many of the employees that she works with, and she works with employees on L&I, are out of work because of ergonomic type injuries. And that's all I have to say.

MR. WALTERS: Thank you very much. As you know, we are required by law to send you the results of these hearings, and so, could we get your address and so forth before you leave?

MR. WERT: I filled out a form.

MR. WALTERS: Thank you. Is there anyone else who would like to testify?

(No response.)

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C L O S I N G C O M M E N T S

MR. WALTERS: Hearing none, I'd just would like to remind folks that the deadline for submitting written comments is the 14th of February 2000, and I would like to thank all of you for coming to this meeting.

The hearing is adjourned at 8:01 p.m.

Thank you all.

(Hearing adjourned at 8:01 p.m.)

C E R T I F I C A T E

STATE OF WASHINGTON)
) ss
COUNTY OF KING)

I, the undersigned officer of the Court, under my commission as a Notary Public in and for the State of Washington, hereby certify that this is a true transcript of the Public Hearing regarding Ergonomics; that the said hearing was taken stenographically before me and thereafter transcribed under my direction.

IN WITNESS WHEREOF, I have hereunto set my hand and seal this 21st of January, 2000.

Wade J. Johnson
NOTARY PUBLIC in and for the State
of Washington, residing at Renton.
My commission expires 11/9/02.